

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death: Page 4

may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

13623

CERTIFICATE OF DEATH

Reg. Dist. No.

13595

1. PLACE OF DEATH a. COUNTY Cecil		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE Maryland					
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) North East		b. COUNTY Cecil					
c. LENGTH OF STAY IN 1b 8 Years		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) North East					
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION		d. STREET ADDRESS Main Street					
3. NAME OF DECEASED (Type or print) Martha		First E	Middle Abrahams	4. DATE OF DEATH 12	Month 23	Day 1959	Year
5. SEX Female	6. COLOR OR RACE white	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	8. DATE OF BIRTH 11-27-1870	9. AGE (In years last birthday) 89	IF UNDER 1 YEAR yrs. Months	IF UNDER 24 HRS. Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY —		11. BIRTHPLACE (State or foreign country) North East, Maryland		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Thomas C. McCracken		14. MOTHER'S MAIDEN NAME Martha Browne		Address			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no		16. SOCIAL SECURITY NO. —		17. INFORMANT Howard Abrahams		18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 450.0 DUE TO Generalized Arteriosclerosis INTERVAL BETWEEN ONSET AND DEATH 10 years	
Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause last. —		(b) —		(c) —			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) Chronic Interstitial Cystitis						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) —					
20c. TIME OF INJURY Month, Day, Year Hour o. m. — 19 p. m. —		20d. INJURY OCCURRED While at work <input type="checkbox"/> of work <input checked="" type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) —		20f. (City or town) (County) (State) —	
21. I certify that I attended the deceased from <u>June</u> , 19 <u>52</u> , to <u>23 Dec</u> , 19 <u>59</u> , that I last saw the deceased alive on <u>23 Dec</u> , 19 <u>59</u> , and that death occurred at <u>6:15 A.M.</u> from the causes and on the date stated above. ACTUAL SIGNATURE <u>Klaus H. Huebner</u> M.D. ADDRESS (Street, city or town, state) <u>North East, Md</u> DATE SIGNED <u>12/23/59</u>							
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 12-26-1959		22c. NAME OF CEMETERY OR CREMATORIAL North East Methodist		22d. LOCATION (City, town, or county) (State) North East, Cecil Co., Maryland	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Joseph R. Grant</u> Joseph R. Grant		ADDRESS North East, Maryland		24a. REC'D BY REGISTRAR DATE DEC 28 '59		24b. REGISTRAR'S SIGNATURE <u>Arthur S. Kline</u>	

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

13614

CERTIFICATE OF DEATH

Reg. Dist. No.

13596

HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death: Page 4
 may be referred to by the hospital or attending physician.

FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, it should be filed with the funeral director. Page 3 should be detached for use as the burial-transit Permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

1. PLACE OF DEATH a. COUNTY <i>Cecil</i>		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <i>MD.</i> b. COUNTY <i>Cecil</i>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>EIKTON</i>		c. LENGTH OF STAY IN 1b <i>2 months</i>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>21 EIKTON</i>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <i>—</i>		d. STREET ADDRESS <i>323 Curtis Ave</i>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print)	First <i>Lydia</i>	Middle <i>GREENE</i>	Last <i>Briley</i>	4. DATE OF DEATH <i>12 - 8 - 1959</i>	Month Day Year
5. SEX <i>Female</i>	6. COLOR OR RACE <i>W</i>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>3/16/1878</i>	9. AGE (In years from birth) <i>81</i>	IF UNDER 1 YEAR Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>House wife</i>		10b. KIND OF BUSINESS OR INDUSTRY <i>HOME</i>		11. BIRTHPLACE (State or foreign country) <i>Delaware</i>	
13. FATHER'S NAME <i>John GREENE</i>		14. MOTHER'S MAIDEN NAME <i>MARTHA ALLEN</i>		12. CITIZEN OF WHAT COUNTRY <i>USA</i>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <i>213-36-847</i>		17. INFORMANT <i>Marta Walls, 323 Curtis Ave.</i>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>420.1</i> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c)		Deute Cardiac Dilatation		INTERVAL BETWEEN ONSET AND DEATH <i>1 hour</i>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		Coronary Disease		1 yr.	
20c. TIME OF INJURY Hour a. m. p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> at work <input checked="" type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <i>Nov 1, 1959</i> to <i>Dec 1, 1959</i> that I last saw the deceased alive on <i>Dec 1, 1959</i> , and that death occurred at <i>9:15 AM</i> , from the causes and on the date stated above. ACTUAL SIGNATURE <i>John Greenwell</i> PHYSICIAN'S NAME (Type) <i>Edward J. Greenwell M.D.</i>		M.D.		ADDRESS (Street, city or town, state) <i>1211 1/2 E. 21st St., Baltimore, Md.</i>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <i>BURIAL</i>		22b. DATE THEREOF <i>12/11/59</i>		22c. NAME OF CEMETERY OR CREMATORIAL <i>CECILTON CEM.</i>	
23. FUNERAL DIRECTOR'S SIGNATURE <i>Edward Fellows, Wellington, Md.</i>		ADDRESS <i>—</i>		24a. REC'D BY REGISTRAR DATE <i>DEC 11 '59</i>	
				24b. REGISTRAR'S SIGNATURE <i>John & Anna</i>	

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MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

13615

CERTIFICATE OF DEATH

Reg. Dist. No.

13597

1. PLACE OF DEATH a. COUNTY. <i>Cecil</i>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <i>Md.</i>								
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Elkton Md.</i>		c. LENGTH OF STAY IN 1b <i>1 Week</i>								
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <i>Devine Nursing Home</i>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Colora Md.</i>								
d. STREET ADDRESS <i>1</i>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>								
3. NAME OF DECEASED (Type or print) <i>Levie Hoag Balderston</i>		First <i>Levie</i>	Middle <i>Hoag</i>	Last <i>Balderston</i>	4. DATE OF DEATH <i>Dec. 26,</i>	Month <i>Dec.</i>	Day <i>26,</i>	Year <i>1959</i>		
S. SEX <i>Male</i>	6. COLOR OR RACE <i>White</i>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	B. DATE OF BIRTH <i>5/18/1891</i>	9. AGE (In years last birthday) <i>68 yrs.</i>	IF UNDER 1 YEAR Months <i>0</i>	IF UNDER 24 HRS. Days <i>0</i>	Hours <i>0</i>	Min. <i>0</i>		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Farmer</i>		10b. KIND OF BUSINESS OR INDUSTRY <i>Retired</i>		11. BIRTHPLACE (State or foreign country) <i>Cecil Co Md.</i>		12. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>				
13. FATHER'S NAME <i>George Balderston</i>		14. MOTHER'S MAIDEN NAME <i>Myra Atwater</i>								
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <i>No</i>		16. SOCIAL SECURITY NO. <i>300-01-9337</i>		17. INFORMANT <i>Mrs. Anna Balderston</i>		Address <i>Colora, Md.</i>				
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>481X</i>		DUE TO <i>Tuberculosis</i>								
Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause last. (b) <i></i>		DUE TO <i></i>								
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(o) <i>Anticoagulants taken does not Paroxysmal Disease</i>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>								
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <i></i>								
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <i>19</i>		20d. INJURY OCCURRED White Not white of work <input type="checkbox"/> at work <input checked="" type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <i></i>		20f. (City or town) <i></i>		(County) <i></i>	(State) <i></i>	
21. I certify that I attended the deceased from <i>Dec. 4, 1959</i> to <i>Dec. 26, 1959</i> , that I last saw the deceased alive on <i>Dec. 26, 1959</i> , and that death occurred at <i>Elkton, Md.</i> from the causes and on the date stated above.		ADDRESS (Street, city or town, state) <i>2370 Main St.</i>							DATE SIGNED <i>12/26/59</i>	
ACTUAL SIGNATURE <i>Ralph Andrews Jr.</i>		M.D.								
PHYSICIAN'S NAME (Type) <i>S. Ralph Andrews Jr. MD</i>		ELKTON, MARYLAND								
22a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>		22b. DATE THEREOF <i>12/29/59</i>		22c. NAME OF CEMETERY OR CREMATORIAL <i>Friends-Burial</i>		22d. LOCATION (City, town, or county) <i>Colora</i>		(State) <i>Md.</i>		
23. FUNERAL DIRECTOR'S SIGNATURE <i>Elmer E. M. Miller, Rosedale, Md.</i>		ADDRESS <i></i>		24a. REC'D BY REGISTRAR DATE <i>DEC 29 '59</i>		24b. REGISTRAR'S SIGNATURE <i>Elmer E. Miller</i>				

CERTIFICATE OF DEATH

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24	1025	1026	1027	1028	1029	1030	1031	1032	1033	1034	1035	1036	1037	1038	1039	1030	1031	1032	1033	1034	1035	1036	1037	1038	1039	1040	1041	1042	1043	1044	1045	1046	1047	1048	1049	1040	1041	1042	1043	1044	1045	1046	1047	1048	1049	1050	1051	1052	1053	1054	1055	1056	1057	1058	1059	1050	1051	1052	1053	1054	1055	1056	1057	1058	1059	1060	1061	1062	1063	1064	1065	1066	1067	1068	1069	1060	1061	1062	1063	1064	1065	1066	1067	1068	1069	1070	1071	1072	1073	1074	1075	1076	1077	1078	1079	1070	1071	1072	1073	1074	1075	1076	1077	1078	1079	1080	1081	1082	1083	1084	1085	1086	1087	1088	1089	1080	1081	1082	1083	1084	1085	1086	1087	1088	1089	1090	1091	1092	1093	1094	1095	1096	1097	1098	1099	1090	1091	1092	1093	1094	1095	1096	1097	1098	1099	1100	1101	1102	1103	1104	1105	1106	1107	1108	1109	1100	1101	1102	1103	1104	1105	1106	1107	1108	1109	1110	1111	1112	1113	1114	1115	1116	1117	1118	1119	1110	1111	1112	1113	1114	1115	1116	1117	1118	1119	1120	1121	1122	1123	1124	1125	1126	1127	1128	1129	1120	1121	1122	1123	1124	1125	1126	1127	1128	1129	1130	1131	1132	1133	1134	1135	1136	1137	1138	1139	1130	1131	1132	1133	1134	1135	1136	1137	1138	1139	1140	1141	1142	1143	1144	1145	1146	1147	1148	1149	1140	1141	1142	1143	1144	1145	1146	1147	1148	1149	1150	
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MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

13598

Reg. Dist. No.

TO DEFUNCT MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the same, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your information, or removal.

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1. PLACE OF DEATH a. COUNTY Cecil		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland				
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Chesapeake		c. LENGTH OF STAY IN lb all life				
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Dr. H. V. Davis Office		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				
3. NAME OF DECEASED (Type or print)	First Timothy	Middle Banks	4. DATE OF DEATH Month 12 Day 8 Year 19 59			
5. SEX M	6. COLOR OR RACE W	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> b. DATE OF BIRTH WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> 9-24-58	9. AGE (In years last birthday) 1 yr. IF UNDER 1 YEAR Months 2 Days 15 Hours Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Infant		10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country) Elkton, Md.			
13. FATHER'S NAME James D. Bedwell		14. MOTHER'S MAIDEN NAME Mary Ellen Banks				
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) NO		16. SOCIAL SECURITY NO.	17. INFORMANT Mrs. Mary E. Bedwell, Chesapeake City, Md. Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Sub dural hemorrhage DUE TO 9040 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c)						
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) 19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>						
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) Fell backwards and hit the floor				
20c. TIME OF INJURY 9-24-59 a.m. XXX	Month, Day, Year 12 8 19 59	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) Home	20f. (City or town) Chesapeake City	(County) Cecil	(State) Md.
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and find that death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/> .						
ACTUAL SIGNATURE <i>R. C. Dodson</i>	DATE SIGNED 12-8-59					
EXAMINER'S NAME (Type) R. C. Dodson	M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input type="checkbox"/>					
22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL	22b. DATE THEREOF DEC. 10, 1959	22c. NAME OF CEMETERY OR CREMATORIUM BETHEL CEMETERY	22d. LOCATION (City, town, or county) NR. CHESAPEAKE CITY (State) Md.			
23. FUNERAL DIRECTOR'S SIGNATURE PIPPIN FUNERAL HOME Donald J. Lee	ADDRESS ELKTON MD.	24a. REC'D BY REGISTRAR DATE DEC 15 '59	24b. REGISTRAR'S SIGNATURE Arthur S. Trahan			

SCHLESINGER, L. B.

1
TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 1 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

Item 1 FilmG253 12-11-59 et

CERTIFICATE OF DEATH

Reg. Dist. No.

13599

13625

1. PLACE OF DEATH a. COUNTY Cecil		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Penn.	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Perry Point, Md.		c. LENGTH OF STAY IN 1b 9 Days	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION V.A. Hospital		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Nottingham	
		d. STREET ADDRESS Rt #2	

3. NAME OF DECEASED (Type or print)	First ROY R. CAMPBELL	Middle	Lost	4. DATE OF DEATH December 4,	Month	Day	Year 1959
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5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	B. DATE OF BIRTH 10-11-20	9. AGE (In years lost birthday) 39 yrs.	IF UNDER 1 YEAR Months	IF UNDER 24 HRS. Days	Hours	Min.
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10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Mechanic	10b. KIND OF BUSINESS OR INDUSTRY Aberdeen Pr Gnd	11. BIRTHPLACE (State or foreign country) Nottingham, Pa.	12. CITIZEN OF WHAT COUNTRY? USA
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13. FATHER'S NAME Clarence Campbell	14. MOTHER'S MAIDEN NAME Ida McCall
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15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)	16. SOCIAL SECURITY NO. WW II	INFORMANT V. A. Hospital, Perry Point, Md.	Address
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18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]		INTERVAL BETWEEN ONSET AND DEATH Unknown
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) CARCINOMA OF LUNG - Anaplastic		
163X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause last. (b) DUE TO (c)		

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
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20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)		
20c. TIME OF INJURY Hour a. m. p. m.	Month 19	Day	Year
20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)

21. I certify that the deceased died on the date stated above, and that death occurred at 9:35A M, from the causes and on the date stated above.			
ACTUAL SIGNATURE J. L. Garey		ADDRESS (Street, city or town, state)	DATE SIGNED

PHYSICIAN'S NAME (Type)	Clinical Pathologist.		
J. L. GAREY, MD			

22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF Dec 5 1959	22c. NAME OF CEMETERY OR CREMATORIAL Oxford Cem.	22d. LOCATION (City, town, or county) Oxford, Chester Co
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23. FUNERAL DIRECTOR'S SIGNATURE Leva Patterson, Perryville, Md.	ADDRESS	24a. REC'D BY REGISTRAR J. M. LOKEMAN	24b. REGISTRAR'S SIGNATURE Arthur S. Kline
		DATE 12/4/59	DEC 9 '59

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

13626

CERTIFICATE OF DEATH

Reg. Dist. No.

13600

1. PLACE OF DEATH a. COUNTY Cecil		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Md.	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Chesapeake City		c. LENGTH OF STAY IN 1b Life	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Morgan Nursing Home		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) Zachary		First Taylor	Middle Cooling, Jr.
4. DATE OF DEATH Dec.		Month 12,	Day 19
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Apr. 28, 1880
9. AGE (In years last birthday) 79 yrs.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Ret. U.S. Govt.	
11. BIRTHPLACE (State or foreign country) Chesapeake City, Md.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Zachary T. Cooling, Sr.		14. MOTHER'S MAIDEN NAME Josephina Loveless	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. 169-20-1497 17. INFORMANT Mrs. Marie S. Cooling, Chesapeake City, Md.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Bronchiogenic carcinoma with</u> 162.1 DUE TO <u>metastases</u> INTERVAL BETWEEN Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause last. (b) DUE TO (c)		ONSET AND DEATH about 1 yr.	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Nat while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <u>Sept. 30, 1959</u> to <u>Dec. 12, 1959</u> that I last saw the deceased alive on <u>Dec. 8, 1959</u> , and that death occurred at <u>6:00 A.M.</u> from the causes and on the date stated above. ACTUAL SIGNATURE <u>Ralph Andrews, Jr.</u> ADDRESS (Street, city or town, state) <u>M.D. 233 E. Main St.</u> DATE SIGNED <u>12/12/59</u>			
PHYSICIAN'S NAME (Type) S. Ralph Andrews, Jr., M.D.		Elkton Maryland	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 12/15/59	22c. NAME OF CEMETERY OR CREMATORIUM Bethel Cemetery
22d. LOCATION (City, town, or county) Nr. Chesapeake City, Md.		24a. REC'D BY REGISTRAR DATE DEC 21 '59	
23. FUNERAL DIRECTOR'S SIGNATURE Pippin Funeral Home		ADDRESS Elkton	24b. REGISTRAR'S SIGNATURE Arthur S. Kraus

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

13627

CERTIFICATE OF DEATH

Reg. Dist. No.

13691

1. PLACE OF DEATH a. COUNTY Cecil		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE District of Columbia	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Ferry Point		c. LENGTH OF STAY IN 1b 15 days	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Veterans Administration Hospital		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Washington	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		d. STREET ADDRESS 607 Anacostia Ave., N.E.	
3. NAME OF DECEASED (Type or print)	First James	Middle M	Last Cornnor
4. DATE OF DEATH	Month 12	Day 12	Year 19 59
5. SEX Male	6. COLOR OR RACE Negro	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	8. DATE OF BIRTH 3-9-15
9. AGE (In years last birthday) 44 yrs.	10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Porter	11. BIRTHPLACE (State or foreign country) Copes, S.C.	12. CITIZEN OF WHAT COUNTRY? U.S.A.
13. FATHER'S NAME Robert Cornnor		14. MOTHER'S MAIDEN NAME Katie Kitt	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) Yes	16. SOCIAL SECURITY NO. (If yes, give war or dates of service) WW II	INFORMANT Not Ascertainable Hospital Records, VAH, Perry Point, Md.	Address
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 443X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause first. (b) DUE TO Azotemia, uremia (Clinical) INTERVAL BETWEEN ONSET AND DEATH 7 days			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) Arteriosclerosis, generalized, severe			
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)		21. I certify that I attended the deceased from 11-27- , 19 59, to 12-12- , 19 59, and that death occurred at 10:35A , from the causes and on the date stated above. ADDRESS (Street, city or town, state) VA Hospital, Perry Point, Md.	
ACTUAL SIGNATURE <i>J. L. Garey</i>		DATE SIGNED 12-12-59	
PHYSICIAN'S NAME (Type) J. L. GAREY, M.D.		22a. BURIAL, CREMATION REMOVAL (Specify) BURIAL	
22b. DATE THEREOF 12-16-59		22c. NAME OF CEMETERY OR CREMATORIUM Arlington National Ceme.	
22d. LOCATION (City, town, or county) Arlington, Virginia		(State)	
23. FUNERAL DIRECTOR'S SIGNATURE <i>John J. Stewart</i>		24a. REC'D BY REGISTRAR DATE DEC 16 '59	
ADDRESS 30-24 37th St		24b. REGISTRAR'S SIGNATURE <i>Arthur S. Evans</i>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours of death. Page 4
may be relied on by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, it may be filed with
page 3 should be detached for use as the burial-transit permit. Then please remove carbon paper. Pages 1 and 2 should be filed with
the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 5 may be retained for your files. To FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File Pages 1 and 2 with the registrar prior to burial, cremation, or removal.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

13615

Reg. Dist. No.

13602

1. PLACE OF DEATH a. COUNTY Cecil		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE Md. b. COUNTY Cecil	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Elkton		c. LENGTH OF STAY IN 1b all life	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) 520 North St.		e. STREET ADDRESS 520 North St.	
3. NAME OF DECEASED (Type or print) Harry		First 0	Middle Dean
4. DATE OF DEATH Month 12 Day 2 Year 19 59	5. SEX M	6. COLOR OR RACE W	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>
8. DATE OF BIRTH 2-11-1870	9. AGE (In years last birthday) 89 yrs.	10. IF UNDER 1 YEAR Months 0 Days 0	11. IF UNDER 24 HRS. Hours 0 Min. 0
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Ship Carpenter		10b. KIND OF BUSINESS OR INDUSTRY Retired	
11. BIRTHPLACE (State or foreign country) Delaware		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Jacob Dean		14. MOTHER'S MAIDEN NAME Elizabeth Oliver	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no		16. SOCIAL SECURITY NO. 222-07-0228	
17. INFORMANT Ralph Dean, 520 North St. Elkton, Md.		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]			
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Acute Coronary Occlusion			
DUE TO 420.1			
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause first. (b) _____			
DUE TO (c) _____			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 1b.)	
20c. TIME OF INJURY Hour o. m. 19 p. m.		20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and find that death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .			
ACTUAL SIGNATURE R.C. Dodson		DATE SIGNED 12-2-59	
EXAMINER'S NAME (Type) R.C. Dodson		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 12/5/59	22c. NAME OF CEMETERY OR CREMATORIAL Elkton Cemetery
22d. LOCATION (City, town, or county) Elkton,		(State) Md.	
23. FUNERAL DIRECTOR'S SIGNATURE PIPPIN FUNERAL HOME		ADDRESS Donald J. Dee Elkton,	24a. REC'D BY REGISTRAR DATE DEC 8 '59
			24b. REGISTRAR'S SIGNATURE Arthur S. Kraus

THE STATE BOARD OF HEALTH - BIRMINGHAM

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

115

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10-15-10

1 MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

13603

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the date, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your file.
 TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File Pages 1 and 2 with the registrar prior to burial, cremation, or removal.

13628		Reg. Dist. No.							
1. PLACE OF DEATH a. COUNTY Cecil		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE Maryland							
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rising Sun		b. COUNTY Cecil							
c. LENGTH OF STAY IN 1b 22 yrs		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rising Sun							
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) 13. S. Walnut St.		d. STREET ADDRESS 13. S. Walnut St.							
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>									
3. NAME OF DECEASED (Type or print) Cornelia McChesney		First Cornelia	Middle McChesney	Last Dunn	4. DATE OF DEATH 12 9 1959	Month 12	Day 9	Year 1959	
5. SEX F.		6. COLOR OR RACE W		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>		8. DATE OF BIRTH 6-8-1878		9. AGE (In years last birthday) 81 yrs.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Abingdon, Va.		12. CITIZEN OF WHAT COUNTRY? U.S.A.			
13. FATHER'S NAME Edward Samuel Haney		14. MOTHER'S MAIDEN NAME Elizabeth Craig Dunn		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no		16. SOCIAL SECURITY NO. 17. INFORMANT		Address Mrs. R.C. Dodson, Rising Sun, Md.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]								INTERVAL BETWEEN ONSET AND DEATH	
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a)		Fracture Left femur							
9040 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.		DUE TO Chronic Myocarditis							
(b)		DUE TO Chronic Myocarditis							
(c)									
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)								19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input checked="" type="checkbox"/> CAUSE OF DEATH		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) Fell at side of bed							
20c. TIME OF INJURY Month, Day, Year 8:30 a.m. 12-9 1959		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) Home		20f. (City or town) Rising Sun		(County) Cecil	
								(State) Md.	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input type="checkbox"/> , Inquiry <input type="checkbox"/> , and find that death resulted from: Natural causes <input type="checkbox"/> , Accident <input checked="" type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .									
ACTUAL SIGNATURE <i>R.C. Dodson</i>								DATE SIGNED 12-9-59	
EXAMINER'S NAME (Type) R.C. Dodson									
22a. BURIAL, CREMATION, REMOVAL, (Specify) Burial		22b. DATE THEREOF Dec. 12, 1959		22c. NAME OF CEMETERY OR CREMATORIAL Sinking Springs Cemetery, Abingdon		22d. LOCATION (City, town, or county) Abingdon, Va.		(State)	
23. FUNERAL DIRECTOR'S SIGNATURE <i>J. Earl Tyson</i>		ADDRESS Rising Sun, Md.		24a. REC'D BY REGISTRAR DEC 11 '59		24b. REGISTRAR'S SIGNATURE <i>Orlina S. Kraus</i>			

EXAMINER'S CERTIFICATE OF DEATH

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MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

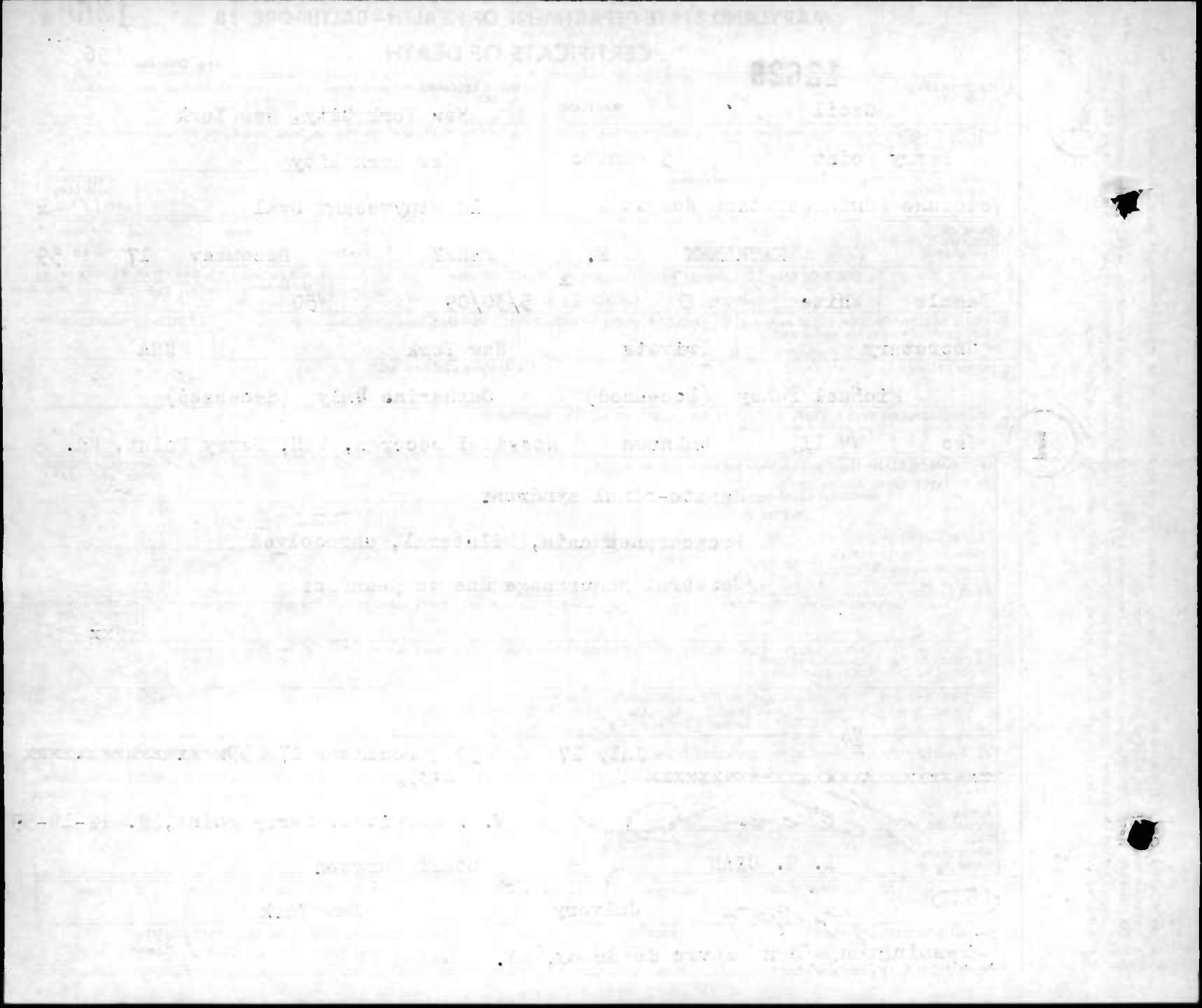
13604

CERTIFICATE OF DEATH

Reg. Dist. No. 96

13629

1. PLACE OF DEATH a. COUNTY Cecil		b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Perry Point		c. LENGTH OF STAY IN 1b 5 months		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE New York City, New York		b. COUNTY	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Veterans Administration Hospital		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) New York City		d. STREET ADDRESS 10 Stuyvesant Oval		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) KATHLEEN		First	Middle	Last	4. DATE OF DEATH December	Month	Day	Year	
5. SEX Female		6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/>	B. DATE OF BIRTH 5/30/09	9. AGE (In years last birthday) 50 yrs.	IF UNDER 1 YEAR Months	IF UNDER 24 HRS. Days	Hours	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Secretary		10b. KIND OF BUSINESS OR INDUSTRY Private		11. BIRTHPLACE (State or foreign country) New York		12. CITIZEN OF WHAT COUNTRY? USA			
13. FATHER'S NAME Michael Fahey (Deceased)		14. MOTHER'S MAIDEN NAME Catherine Daly (deceased)		Address					
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) Yes		16. SOCIAL SECURITY NO. WW II		INFORMANT Hospital Records, VAH, Perry Point, Md.		17. INTERVAL BETWEEN ONSET AND DEATH			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]									
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Hepato-renal syndrome DUE TO 583X Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause last. (b) Bronchopneumonia, bilateral, unresolved DUE TO (c) Cerebral hemorrhage due to jaundice									
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)									
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)							
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County)		(State)	
21. I certify that I attended the deceased from July 17, 1959, to December 17, 1959, and that death occurred at 2:35 PM, from the causes and on the date stated above. X XXXXXXXXXXXXXXXXXXXXXXX and ADDRESS (Street, city or town, state) DATE SIGNED		ACTUAL SIGNATURE L. G. CIAN PHYSICIAN'S NAME (Type) M.D. V.A. Hospital, Perry Point, Md. 12-18-59							
22a. BURIAL, CREMATION, REMOVAL (Specify)		22b. DATE THEREOF 12/19/59		22c. NAME OF CEMETERY OR CREMATORIAL Calvary		22d. LOCATION (City, town, or county) New York			
23. FUNERAL DIRECTOR'S SIGNATURE Pennington & Son		ADDRESS Havre de Grace, Md.		24a. REC'D BY REGISTRAR DATE DEC 29 '59		24b. REGISTRAR'S SIGNATURE Arthur S. Kline			



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

Reg. Dist. No. 96

13605

1		13630		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)	
M		a. STATE Maryland		b. COUNTY Harford	
050		b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Perry Point		c. LENGTH OF STAY IN 1b 1 Month	
1		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Whiteford		d. STREET ADDRESS None	
2		d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Veterans Administration Hospital		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
1		3. NAME OF DECEASED (Type or print)	First WILSON	Middle J.	Last GRAFTON
2		4. DATE OF DEATH	Month December	Day 1	Year 1959
1		5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	8. DATE OF BIRTH May 2, 1896
2		9. AGE (In years last birthday) 63 yrs.	10. IF UNDER 1 YEAR Months Days	11. IF UNDER 24 HRS. Hours Min.	
1		10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Paperhanger		10b. KIND OF BUSINESS OR INDUSTRY Home Remodeling	
2		11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? USA	
1		13. FATHER'S NAME JOHN A. GRAFTON		14. MOTHER'S MAIDEN NAME ANNE E. THOMAS	
2		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) Yes		16. SOCIAL SECURITY NO. 219-14-2461 Hospital Records, VA Hospital, Perry Point, Md.	
1		17. INFORMANT		Address	
2		18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Adenocarcinoma of the rectum with</u> DUE TO <u>obstruction of the terminal ileum</u> INTERVAL BETWEEN ONSET AND DEATH unknown 154x			
1		Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause lost. (b) DUE TO (c)			
2		PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
1		20c. TIME OF INJURY Month, Doy, Year Hour a. m. 19 p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
2		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) VA		20f. (City or town) (County) (State)	
1		21. I certify that I attended the deceased from November 1, 1959, to December 1, 1959, XXXXXX and that death occurred at 12:15 AM, from the causes and on the date stated above.		ADDRESS (Street, city or town, state)	
2				DATE SIGNED	
1		ACTUAL SIGNATURE <i>J. L. Garey</i>		M.D. V.A. Hospital, Perry Point, Md. 12-1-59	
2		PHYSICIAN'S NAME (Type) J. L. GAREY		Clinical Pathologist	
1		22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 12-4-1959	
2		22c. NAME OF CEMETERY OR CREMATORIUM Centre Cemetery		22d. LOCATION (City, town, or county) (State) Forrest Hills, Maryland	
1		23. FUNERAL DIRECTOR'S SIGNATURE <i>Harkins</i>		24a. REC'D BY REGISTRAR DEC 3 '59	
2		ADDRESS HARKINS FUNERAL HOME, Delta, Penna.		24b. REGISTRAR'S SIGNATURE <i>Arthur S. Traas</i>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4
may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, it should be filed with
page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with
the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

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Digitized by srujanika@gmail.com

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, it should be filed with page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

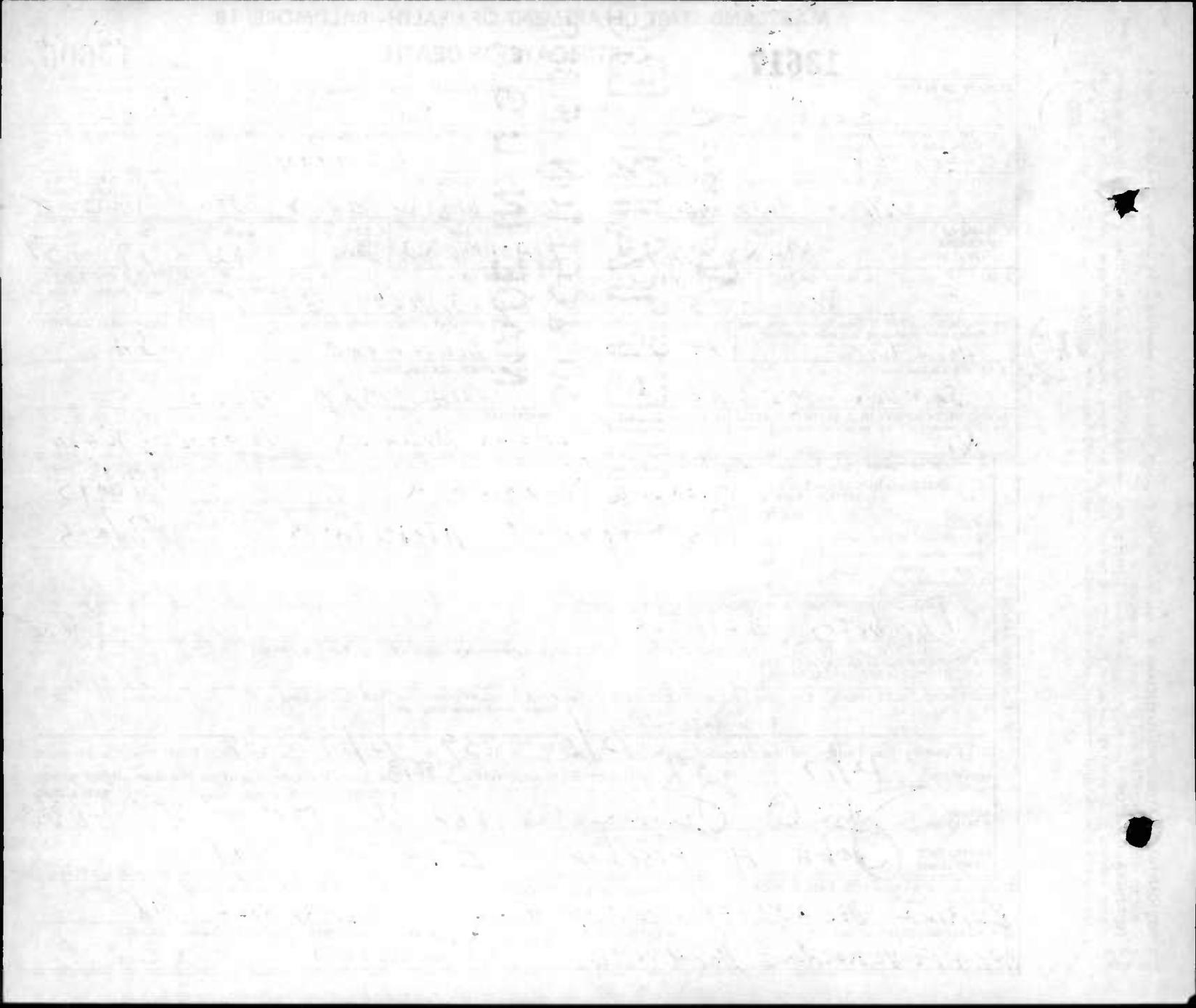
MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

13617

CERTIFICATE OF DEATH

Reg. Dist. No. 13606

1. PLACE OF DEATH a. COUNTY <i>Cecil</i>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <i>Md.</i>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>ELKTON</i>		c. LENGTH OF STAY IN 1b <i>5 YRS</i>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <i>UNION HOSPITAL</i>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print)	First <i>MARY JANE</i>	Middle <i>HAMMOND</i>	4. DATE OF DEATH Month <i>12</i> Day <i>17</i> Year <i>1959</i>
5. SEX <i>F.</i>	6. COLOR OR RACE <i>W.</i>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>May 23 1904</i>
9. AGE (In years lost birthday) yrs. <i>55</i>	10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>HOUSE WIFE</i>	10b. KIND OF BUSINESS OR INDUSTRY <i>AT HOME</i>	11. BIRTHPLACE (State or foreign country) <i>DELAWARE</i>
12. CITIZEN OF WHAT COUNTRY? <i>USA</i>	13. FATHER'S NAME <i>SAMUEL MEDKEFF</i>		
14. MOTHER'S MAIDEN NAME <i>IDA MAY BEZL</i>	15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <i>No</i>		
16. SOCIAL SECURITY NO. <i>LILLIAN BYWATER</i>	INFORMANT <i>LILLIAN BYWATER</i>	Address <i>SEATTLE, WASH.</i>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>527.0</i> Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause last. (b) (c) DUE TO <i>Broncho Pneumonia</i> DUE TO <i>Post-operative Atelectasis</i> DUE TO <i>Diabetes mellitus</i>			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Hour o. m. p. m.	Month 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <i>12/6</i> , 19 <i>59</i> to <i>12/17</i> , 19 <i>59</i> that I last saw the deceased alive on <i>12/17</i> , 19 <i>59</i> , and that death occurred at <i>5501 M.</i> from the causes and on the date stated above.			
ACTUAL SIGNATURE <i>John A. Fischer</i>	PHYSICIAN'S NAME (Type) <i>John A. Fischer</i>	ADDRESS (Street, city or town, state) <i>162 W. MAIN ST. ELKTON, MD</i>	DATE SIGNED <i>12/18/59</i>
22a. BURIAL, CREMATION, REMOVAL (Specify) <i>BURIAL</i>	22b. DATE THEREOF <i>DEC 23, 1959</i>	22c. NAME OF CEMETERY OR CREMATORIAL <i>CHERRY HILL</i>	22d. LOCATION (City, town, or county) (State) <i>CHERRY HILL, MD.</i>
23. FUNERAL DIRECTOR'S SIGNATURE <i>PAPPIN FUNERAL HOME Donald M. Pappin</i>	ADDRESS <i>ELKTON, MD.</i>	24a. REC'D BY REGISTRAR DATE <i>DEC 30 '59</i>	24b. REGISTRAR'S SIGNATURE <i>Arthur S. Trahan</i>



TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the same, writing the word "pending", in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files or for burial, cremation, or removal.

VS. A15ME(5)
5M 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

13697

Reg. Dist. No. 96

1. PLACE OF DEATH a. COUNTY Cecil		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE Maryland b. COUNTY Cecil	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Perry Point		c. LENGTH OF STAY IN lb 5 minutes	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) VAH, Perry Point, Maryland		e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) X North East	
3. NAME OF -DECEASED (Type or print) WILLIAM Harry HOFFMAN		4. DATE OF DEATH 11* 12-15 1959	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>	8. DATE OF BIRTH 5-8-83
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Laborer		10b. KIND OF BUSINESS OR INDUSTRY Regular laborer	
10c. FATHER'S NAME Samuel W. Hoffman		11. BIRTHPLACE (State or foreign country) Pickway, Pennsylvania	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) Yes		16. SOCIAL SECURITY NO. 214-12-0879 17. INFORMANT Mrs. Charles McCauley, North East, Md.	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 3. Cerebral arteriosclerosis, bilateral thrombosis 10 yrs. 491X Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (b) 1. Bronchopneumonia right lower & middle lobes 36-48 hrs. DUE TO (c) 2. Arteriosclerotic heart disease unknown		INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) Arteriosclerosis generalized severe		19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Hour a. m. p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and find that death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/> ACTUAL SIGNATURE: <i>R. C. Dodson, M.D.</i> DATE SIGNED: 12-15-59			
EXAMINER'S NAME (Type) R. C. DODSON, M.D.		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 12/18/59	
22c. NAME OF CEMETERY OR CREMATORIAL Northeast Methodist		22d. LOCATION (City, town, or county) North East, Md. (State)	
23. FUNERAL DIRECTOR'S SIGNATURE <i>Joseph R. Grant</i>		ADDRESS JOSEPH R. GRANT, Northeast, Md.	
24a. REC'D BY REGISTRAR DATE DEC 21 '59		24b. REGISTRAR'S SIGNATURE <i>Arthur S. Krause</i>	

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

13618

CERTIFICATE OF DEATH

Reg. Dist. No.

13698

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death: Page 4
 may be referred to by the hospital or attending physician.
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, it should be filed with
 page 3 should be detached for use as the burial-transit permit. Then please remove carbon paper. Pages 1 and 2 should be filed with
 the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

1. PLACE OF DEATH a. COUNTY Cecil		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Md. b. COUNTY Cecil	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Elkton		c. LENGTH OF STAY IN 1b X	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Union Hospital		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Warwick	
d. STREET ADDRESS /		d. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print)	First Katherine	Middle L. Holding	Last Dec. 18 1959
4. DATE OF DEATH	Month	Day	Year
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Jan. 3, 1895
9. AGE (In years lost birthday) 64 yrs.	10. IF UNDER 1 YEAR Months	11. IF UNDER 24 HRS. Days	12. IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housework		10b. KIND OF BUSINESS OR INDUSTRY Own Home	
11. BIRTHPLACE (State or foreign country) Chester Pa.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Walter Parker		14. MOTHER'S MAIDEN NAME Ella M. Tamey	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO.	
17. INFORMANT George R. Holding Warwick Md.		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 331X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause, if any. (b) DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH 10 min Old CVA (cerebro-vascular accident) 1 year	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Completely paralyzed left side.		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Hour o. n. p. m.	Month, Day, Year 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> at work <input type="checkbox"/> of work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)
21. I certify that I attended the deceased from _____, 1959, to _____, 19____, that I last saw the deceased alive on _____, 19____, and that death occurred at _____, from the causes and on the date stated above. ACTUAL SIGNATURE Wallace Obenshain, M.D.		ADDRESS (Street, city or town, state) DATE SIGNED 21 Dec 59	
PHYSICIAN'S NAME (Type) Wallace Obenshain, M.D.		Cecilton, Md.	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF 12-21-59	22c. NAME OF CEMETERY OR CREMATORIUM Galena Cemetery	22d. LOCATION (City, town, or county) Galena Md. (State)
23. FUNERAL DIRECTOR'S SIGNATURE Edward Fellows		24a. REC'D BY REGISTRAR DATE DEC 24 1959	24b. REGISTRAR'S SIGNATURE Edward Fellows

CERTIFICATE OF DEATH

100-5000

DEATH

REGISTRATION

NUMBER

NAME

ADDRESS

CITY

STATE

ZIP

PHONE

CITY

(Employer Telephone Number) 777-5110

Date of Death
Month Year
Place of Death
Name of Hospital

INSTRUCTIONS

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within 24 hours after death. The bottom copy may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be retained for use as a burial transit permit.

VS A15C 4-55 10M

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

13632 CERTIFICATE OF DEATH

13609

Reg. Dist. No.

1. PLACE OF DEATH		2. USUAL RESIDENCE (HOME) OF DECEASED	
COUNTY CITY (If outside corporate limits, write RURAL OR and give nearest town) TOWN	Cecil North East	MARYLAND LENGTH OF STAY (In this place) 25 years	STATE Maryland CITY (If outside corporate limits, write RURAL and give nearest town) TOWN Rural North East
HOSPITAL OR INSTITUTION OR STREET ADDRESS		STREET ADDRESS (If rural give location)	
3. NAME OF DECEASED (Type or Print)		4. DATE (Month) (Day) (Year)	
(First) Rudolph (Middle) E. (Last) Jernstrom		OF DEATH 12 19 1959	
5. SEX Male	6. COLOR OR RACE White	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) Married	8. DATE OF BIRTH 6-25-1902
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Carpenter		10b. KIND OF BUSINESS OR INDUSTRY Building	
11. BIRTHPLACE (State or foreign country) Finland		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Anders W. Jernstrom		14. MOTHER'S MAIDEN NAME Eva Nyberg	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unk.)		16. SOCIAL SECURITY NO. 214-18-2696	
17. INFORMANT & ADDRESS Hilma Leivonen Jernstrom North East, Md		18. MEDICAL CERTIFICATION	
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH			
420.1 IMMEDIATE CAUSE (A) Acute Coronary Thrombosis ANTECEDENT CAUSE(S) DUE TO DISEASES OR CONDITIONS, IF ANY, (B) Aortic Insufficiency GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. DUE TO (C) Hypertrophy of Heart			
INTERVAL BETWEEN ONSET AND DEATH (1) hour			
(9) months			
(9) months			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH. None			
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION	
20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		INTERVAL BETWEEN ONSET AND DEATH (1) hour	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)	
21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)		21d. TIME OF INJURY (Month) (Day) (Year) (Hour)	
21e. INJURY OCCURRED M. at work <input type="checkbox"/> Not white <input type="checkbox"/> at work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?	
22. I hereby certify that I attended the deceased from March 3, 1959, to Dec. 19, 1959, that I last saw the deceased alive on Dec. 1, 1959, and that death occurred at 8:20 P.M. from the causes and on the date stated above. SIGNATURE James L. Johnson DATE SIGNED M.D. 245 E. High, St. Elkton, Md. 12/21/59			
23. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		DATE THEREOF 12-23-1959	
NAME OF CEMETERY OR CREMATORIAL North East Methodist		LOCATION (City, town, or county) North East, Cecil Co., Md	
24. REC'D BY REGISTRAR DATE DEC 23 '59		25. FUNERAL DIRECTOR'S SIGNATURE ADDRESS Joseph R. Grant North East, Maryland	
REGISTRAR'S SIGNATURE Arthur S. Haas			

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

13610

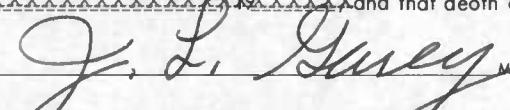
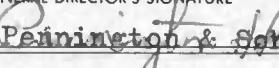
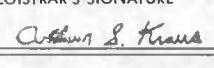
13633

CERTIFICATE OF DEATH

Reg. Dist. No. 96

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4
 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

1. PLACE OF DEATH a. COUNTY Cecil		b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Perry Point		c. LENGTH OF STAY IN 1b 2 yrs. 10 mo. 22 days		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE District of Columbia		b. COUNTY District of Columbia	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Veterans Administration Hospital		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Washington		d. STREET ADDRESS 1231 R. Street, N.E.		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) GUY		First GUY	Middle (NMI)	Last KINZER	4. DATE OF DEATH December 10 1959	Month December	Day 10	Year 1959	
5. SEX Male	6. COLOR OR RACE Negro	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>		8. DATE OF BIRTH 2-18-88		9. AGE (In years last birthday) 71 yrs.	IF UNDER 1 YEAR Months 0	IF UNDER 24 HRS. Days 0	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) unknown		10b. KIND OF BUSINESS OR INDUSTRY unknown		11. BIRTHPLACE (State or foreign country) Virginia		12. CITIZEN OF WHAT COUNTRY? USA			
13. FATHER'S NAME James H. Kinzer				14. MOTHER'S MAIDEN NAME Mary F. Kiyte					
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) Yes		16. SOCIAL SECURITY NO. WW I		INFORMANT Hospital Records, VAH, Perry Point, Md.		Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]									
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Infarction hemorrhagic of the heart									
DUE TO 420.0									
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Arteriosclerotic heart disease									
DUE TO (c) Arteriosclerosis, generalized									
DUE TO unknown									
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)									
Arteriosclerosis, generalized									
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>									
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) Arteriosclerosis, generalized							
20c. TIME OF INJURY Hour a. m. p. m. VA		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Name, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)			
19									
21. I certify that I attended the deceased from January 18, 1957 to December 10 1959 and that death occurred on December 10 1959 at 11:20 AM from the causes and on the date stated above.									
ADDRESS (Street, city or town, state) Havre de Grace, Md.									
DATE SIGNED 12-11-59									
ACTUAL SIGNATURE 		PHYSICIAN'S NAME (Type) J. L. GAREY Clinical Pathologist							
22a. BURIAL, CREMATION, REMOVAL (Specify) 12/12/59		22b. DATE THEREOF 12/12/59		22c. NAME OF CEMETERY OR CREMATORY Arlington		22d. LOCATION (City, town, or county) (State) Arlington, Virginia			
23. FUNERAL DIRECTOR'S SIGNATURE 		ADDRESS Havre de Grace, Md.		24a. REC'D BY REGISTRAR DEC 17 '59		24b. REGISTRAR'S SIGNATURE 			
VS A15 (4) 15M 9/58									

CONFIDENTIAL - DRAFT - DRAFT - DRAFT - DRAFT - DRAFT - DRAFT - DRAFT

Page 10 of 1132

6961

Planned to 2012

not to be distributed outside

2012

(b) (1)

(b) (1)

not to be distributed outside

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with Form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

13619 Item 3 Film G254 12-30-59 et
065

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

13611

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Cecil		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) b. STATE MARYLAND b. COUNTY Cecil	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Elkton		c. LENGTH OF STAY IN 1b 20 minutes	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Union Hospital		e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) North East	
		f. STREET ADDRESS R.D.1.	
		g. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	

3. NAME OF DECEASED (Type or print)	First James	Middle Graham	Last Thomas	4. DATE OF DEATH Month 12 Day 15 Year 1959
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5. SEX M	6. COLOR OR RACE W	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Aug. 30, 1895	9. AGE (In years last birthday) 64 yrs.	10. IF UNDER 1 YEAR Months 0 Days 0	11. IF UNDER 24 HRS. Hours 0 Min. 0
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10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Lumberman	10b. KIND OF BUSINESS OR INDUSTRY Lumber Lab.	11. BIRTHPLACE (State or foreign country) Md.	12. CITIZEN OF WHAT COUNTRY? U.S.A.
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13. FATHER'S NAME James Thomas Knight	14. MOTHER'S MAIDEN NAME Margaret Allen Stewart
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15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no	16. SOCIAL SECURITY NO. 210-32-4186	17. INFORMANT (Daughter) Jessie E. Burlin. <i>Perryville, Md. Rural</i> Address North East, Md.
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18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]		INTERVAL BETWEEN ONSET AND DEATH
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 420.1 DUE TO Acute Coronary Thrombosis		
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Atherosclerosis DUE TO (c)		
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (o)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>

20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.	20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)		
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20c. TIME OF INJURY Hour a. m. 19 p. m.	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
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21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and find that death resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/>			
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ACTUAL SIGNATURE <i>R.C. Dodson</i>	M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>	DATE SIGNED 12-16-59
EXAMINER'S NAME (Type) R.C. Dodson	ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
DEPUTY MEDICAL EXAMINER <input type="checkbox"/>		

22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF 12-18-1959	22c. NAME OF CEMETERY OR CREMATORIAL Darlington	22d. LOCATION (City, town, or county) (State) Darlington, Md.
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23. FUNERAL DIRECTOR'S SIGNATURE <i>J. A. Patterson & Son</i>	ADDRESS Perryville, Md.	24a. REC'D BY REGISTRAR DATE DEC 21 '59	24b. REGISTRAR'S SIGNATURE Arthur S. Howard
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EDUCATIONAL EXAMINATIONS OF DEAF CHILDREN IN THE STATE OF RIO GRANDE DO SUL

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death: Page 4
 may be relied on by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit Permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

18. MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
 13634 CERTIFICATE OF DEATH
 Reg. Dist. No. 13612

1. PLACE OF DEATH a. COUNTY <i>Cecil</i>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <i>Md.</i>				
b. CITY OR TOWN (If outside corporate limits, write RURAL, and give nearest town) <i>Colora - Rural</i>		c. LENGTH OF STAY IN 1b <i>1/2</i>				
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Colora - Rural</i>				
3. NAME OF DECEASED (Type or print) <i>John</i>		First <i>William</i>	Middle <i>Hiddell</i>			
4. DATE OF DEATH <i>Dec. - 3 - 1959</i>		Month	Day Year			
S. SEX <i>Male</i>	6. COLOR OR RACE <i>White</i>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/>	8. DATE OF BIRTH <i>Oct. 17, 1904</i>			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Farmer</i>		10b. KIND OF BUSINESS OR INDUSTRY <i>own farm</i>	11. BIRTHPLACE (State or foreign country) <i>Hazard Co. Md.</i>			
13. FATHER'S NAME <i>John Henry Hiddell</i>		14. MOTHER'S MAIDEN NAME <i>Clara H. Smith</i>				
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <i>No</i>		16. SOCIAL SECURITY NO. <i>220-20-93</i>	17. INFORMANT <i>Miss Clara Hiddell Colora, Md.</i>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>155.1</i>		Address <i>Colora, Maryland</i>				
DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause last. (b) DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH <i>6 hrs.</i>				
Diseases of Gall Bladder		.4 yr.				
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I						
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)				
20c. TIME OF INJURY Month, Day, Year Hour o. p.m. <i>19</i>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) <i>Colora</i>	(County) <i>Md.</i>	(State)
21. I certify that I attended the deceased from <i>Nov. 1, 1959</i> , to <i>Dec. 3, 1959</i> , that I last saw the deceased alive on <i>Nov. 23, 1959</i> , and that death occurred at <i>11 P.M.</i> , from the causes and on the date stated above.						
ADDRESS (Street, city or town, state) <i>101 N. Main St., Colora, Md.</i>						
DATE SIGNED <i>12/3/59</i>						
ACTUAL SIGNATURE <i>John H. Hiddell</i>		PHYSICIAN'S NAME (Type) <i>John H. Hiddell</i>				
22a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>		22b. DATE THEREOF <i>12/6/1959</i>	22c. NAME OF CEMETERY OR CREMATORIUM <i>West Nottingham Cem. Colora</i>	22d. LOCATION (City, town, or county) (State) <i>Md.</i>		
23. FUNERAL DIRECTOR'S SIGNATURE <i>Tommy E. McMillan</i>		ADDRESS <i>Rising Sun, Md.</i>	24a. REC'D BY REGISTRAR DATE <i>DEC 7 '59</i>	24b. REGISTRAR'S SIGNATURE <i>Arthur S. Trahan</i>		

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TO HOSPITAL ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page **1** may be read by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, it should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death. Page **3** should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages **1** and **2** should be filed with the registrar prior to burial, cremation, or removal.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
13635

CERTIFICATE OF DEATH

Reg. Dist. No. **96**

13613

1. PLACE OF DEATH a. COUNTY Cecil		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Pennsylvania	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Perry Point		c. LENGTH OF STAY IN 1b 10 yrs. 3 mo. 12 days	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Veterans Administration Hospital		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) LOUISE		First F.	Middle MELLIES
Last 5-12-77		4. DATE OF DEATH December 14	Month Day Year 1959
5. SEX Female		6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>
8. DATE OF BIRTH 82 yrs.		9. AGE (In years lost birthday) 82 yrs.	10. IF UNDER 1 YEAR Months 12
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Nurse		10b. KIND OF BUSINESS OR INDUSTRY Nursing	11. BIRTHPLACE (State or foreign country) Pennsylvania
12. CITIZEN OF WHAT COUNTRY? USA		13. FATHER'S NAME Frederick Mellies	
14. MOTHER'S MAIDEN NAME Pauline Muhlic		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) Yes	
16. SOCIAL SECURITY NO. WW I		17. INFORMANT Hospital Records, VAH, Perry Point, Md.	Address
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 581.0		INTERVAL BETWEEN ONSET AND DEATH 5-6 days	
DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO (c)		unknown	
Cirrhosis of the liver		unknown	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) Arteriosclerosis generalized severe		19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. VA 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)
21. I certify that I attended the deceased from September 2, 1949, to December 14, 1959 and last saw the deceased 10/10/59 and that death occurred at 3:00 a.m. from the causes and on the date stated above.		ADDRESS (Street, city or town, state) DATE SIGNED	
ACTUAL SIGNATURE <i>J. L. Garey</i>		22. BURIAL/CREMATION REMOVAL (Specify) 12/15/59	
PHYSICIAN'S NAME (Type) J. L. GAREY		22c. NAME OF CEMETERY OR CREMATORIUM Hollenback	
22d. LOCATION (City, town, or county) Wilkes-Barre, Pa.		23. FUNERAL DIRECTOR'S SIGNATURE Pennington & Son, Havre de Grace, Md.	
24a. REC'D BY REGISTRAR DATE DEC 17 '59		24b. REGISTRAR'S SIGNATURE Arthur S. Kraus	

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

Reg. Dist. No. 96

13614

1. PLACE OF DEATH a. COUNTY Cecil		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE District of Columbia		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Perry Point, Maryland		c. LENGTH OF STAY IN 1b 51 days		
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION VA Hospital, Perry Point, Md.		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Washington		
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		d. STREET ADDRESS 1245 Neal Street, N. E.		
3. NAME OF DECEASED (Type or print)	First HARRY	Middle MILLER	Last 4. DATE OF DEATH December 4, 1959	
5. SEX Male	6. COLOR OR RACE Negro	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH December 5, 1895	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Cook	10b. KIND OF BUSINESS OR INDUSTRY unknown	11. BIRTHPLACE (State or foreign country) McDowell, West Virginia	12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Milton Miller		14. MOTHER'S MAIDEN NAME Agnes Cole		
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) Yes	16. SOCIAL SECURITY NO. WVI	INFORMANT Hospital records, VAH-Perry Point, Md.	Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Arteriosclerotic heart disease 420.0 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause lost. (b) DUE TO Arteriosclerosis, generalized, severe (c) DUE TO Adenocarcinoma of the prostate		INTERVAL BETWEEN ONSET AND DEATH Unknown		
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Adenocarcinoma of the prostate		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>		
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)		
20c. TIME OF INJURY Hour o. m. p. m.	Month, Day, Year 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that the deceased died on that death occurred at 6:00 AM , from the causes and on the date stated above.		ADDRESS (Street, city or town, state) DATE SIGNED		
ACTUAL SIGNATURE <i>J. L. Garey</i>	M.D.	VAH., Perry Point, Md. 12-4-59		
PHYSICIAN'S NAME (Type) J. L. GAREY, MD	Clinical Pathologist.			
22a. BURIAL, CREMATION, REMOVAL (Specify) Removal	22b. DATE THEREOF 12/8/59	22c. NAME OF CEMETERY OR CREMATORIAL Arlington, National	22d. LOCATION (City, town, or county) (State) Arlington, Va.	
23. FUNERAL DIRECTOR'S SIGNATURE <i>Pennington & Son</i>	ADDRESS Havre de Grace, Md.	24a. RECORD BY REGISTRAR DATE Dec 11 1959	24b. REGISTRAR'S SIGNATURE <i>Charles S. Hause</i>	

TO HOSPITAL or ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours of death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon paper. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

1360

1. *What is the primary purpose of the study?*

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1960-1961

22. *Amphibians*

Standford, Calif.

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1962-1963

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13615

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, it should be filed with page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

Reg. Dist. No. 96

13637

1. PLACE OF DEATH a. COUNTY Cecil		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE District of Columbia	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Perry Point		c. LENGTH OF STAY IN 1b 34 days	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Veterans Administration Hospital		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Washington	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		d. STREET ADDRESS 2711 Ft. Baker Drive, S.E.	
3. NAME OF DECEASED (Type or print) WILLIAM		First WILLIAM	Middle M.
Last MOORE		4. DATE OF DEATH December 22	Month Year 19 59
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	8. DATE OF BIRTH 8-21-87
9. AGE (In years last birthday) 72	10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Bookbinder	11. KIND OF BUSINESS OR INDUSTRY Book Binding	12. BIRTHPLACE (State or foreign country) Texas
13. FATHER'S NAME Ransome Moore (Deceased)	14. MOTHER'S MAIDEN NAME Martha E. Moroney (Deceased)		
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) Yes	16. SOCIAL SECURITY NO. 486-10-4286	17. INFORMANT Hospital Records, VAH, Perry Point, Md.	18. ADDRESS
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]			
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Bronchopneumonia, left lower lobe, unresolved 24-36 hours			
420.0 DUE TO			
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Arteriosclerotic heart disease unknown			
DUE TO			
(c)			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a) Arteriosclerosis generalized severe			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. VA 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)
21. I certify that I attended the deceased from November 18, 1959 , to December 22 1959 , and that death occurred at 4:15 PM , from the causes and on the date stated above.			
ACTUAL SIGNATURE <i>J. L. Garey</i>		ADDRESS (Street, city or town, state) M.D. V.A. Hospital, Perry Point, Md. DATE SIGNED 12-23-59	
PHYSICIAN'S NAME (Type) J. L. GAREY		Clinical Pathologist	
22a. BURIAL, CREMATION, REMOVAL* (Specify) Burial	22b. DATE THEREOF 12-28-59	22c. NAME OF CEMETERY OR CREMATORIAL Arlington National	22d. LOCATION (City, town, or county) (State) Arlington, Virginia
23. FUNERAL DIRECTOR'S SIGNATURE <i>W. J. Chambers</i>	ADDRESS Chambers Fun. Home, 517-11th St. S.E. Wash. DC	24a. REG. & COPY REGISTRAR 28-59	24b. REGISTRAR'S SIGNATURE <i>Charles L. Knapp</i>
DATE			

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MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

Item 7 FilmG254 1-14-60 et

13638

CERTIFICATE OF DEATH

Reg. Dist. No. 96

13616

1. PLACE OF DEATH a. COUNTY Cecil		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE District of Columbia	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Perry Point		c. LENGTH OF STAY IN 1b 22yrs. 10mo. 9days Washington	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Veterans Administration Hospital		d. STREET ADDRESS 1127 Fifth Street, N.W.	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print)	First FRANK	Middle A.	Last ORMES
4. DATE OF DEATH	Month December	Day 17	Year 1959
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 7-12-73
9. AGE (In years last birthday) 86 yrs.	10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Laborer	11. KIND OF BUSINESS OR INDUSTRY Odd Jobs	12. BIRTHPLACE (State or foreign country) Iowa
13. FATHER'S NAME Not ascertainable	14. MOTHER'S MAIDEN NAME Not ascertainable	15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) Yes	
16. SOCIAL SECURITY NO. SAW	INFORMANT Unknown	17. CITIZEN OF WHAT COUNTRY? USA	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 196.9 DUE TO Bronchopneumonia bilateral unresolved Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause lost. (b) Osteogenic sarcoma with chest metastasis, DUE TO spleen and gall bladder (c) Athrosclerosis of aortic & mitral valves with stenosis			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) 19. WAS AN AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> Arteriosclerosis of coronary artery without cardiac symp- toms			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) 20c. TIME OF INJURY Month, Day, Year Hour o. m. 19 p. m.	
20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from February 8, 1957, to December 17, 1959, and that death occurred at 1:12 p.m., from the causes and on the date stated above. ADDRESS (Street, city or town, state) ACTUAL SIGNATURE <i>James Cian Jr.</i> DATE SIGNED 12-18-59			
PHYSICIAN'S NAME (Type) LOUIS G. CIAN		Staff Surgeon	
22a. BURIAL, CREMATION, REMOVAL (Specify) REMOVAL		22b. DATE THEREOF 12/21/59	
22c. NAME OF CEMETERY OR CREMATORIAL Baltimore National		22d. LOCATION (City, town, or county) Baltimore, Md. (State)	
23. FUNERAL DIRECTOR'S SIGNATURE Pennington & Son		ADDRESS Havre de Grace, Md.	
24a. REC'D BY REGISTRAR		24b. REGISTRAR'S SIGNATURE Arthur S. Kline	
DATE DEC 29 '59			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4
may be read by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director,
page 3 should be detached for use as the burial-transit permit. Then please remove carbon paper. Pages 1 and 2 should be filed with
the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

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referred ~~to~~ ~~as~~ ~~the~~ ~~area~~ ~~of~~ ~~aircraft~~ ~~point~~

CERTIFICATE OF DEATH

Reg. Dist. No. 96

1. PLACE OF DEATH a. COUNTY Cecil		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Virginia	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Perry Point		c. LENGTH OF STAY IN lb 11 yrs. 1 mo. 9 days	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Veterans Administration Hospital		e. STREET ADDRESS 202 S. Fayette	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		83X-3	
3. NAME OF DECEASED (Type or print)	First CHARLES	Middle (NMI)	Last SIBERT
4. DATE OF DEATH	Month December	Day 14	Year 1959
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	8. DATE OF BIRTH 2-21-84
9. AGE (In years last birthday) 75 yrs.	10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Watchman	11. KIND OF BUSINESS OR INDUSTRY Public School	12. BIRTHPLACE (State or foreign country) Missouri
13. CITIZEN OF WHAT COUNTRY? USA	14. MOTHER'S MAIDEN NAME Not available in records		
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) Yes	16. SOCIAL SECURITY NO. WW I	17. INFORMANT Hospital Records, VAH, Perry Point, Md.	Address
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Arteriosclerotic heart disease</u> DUE TO <u>420.0</u> Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause last. (b) <u>Arteriosclerosis generalized</u> DUE TO (c) _____			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (c) 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m. VA		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <u>November 5, 1948</u> , to <u>December 14 1959</u> and that death occurred at <u>9:30 AM</u> , from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED			
ACTUAL SIGNATURE <u>J. L. Garey</u>		M.D. V.A. Hospital, Perry Point, Md.	
PHYSICIAN'S NAME (Type) J. L. GAREY		Clinical Pathologist	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>12/15/59</u>	22b. DATE THEREOF <u>12/15/59</u>	22c. NAME OF CEMETERY OR CREMATORIAL Arlington National	22d. LOCATION (City, town, or county) Arlington, Va. (State)
23. FUNERAL DIRECTOR'S SIGNATURE <u>Penningson & Son</u>	ADDRESS Havre de Grace, Md.	24a. REC'D BY REGISTRAR DEC 29 1959	24b. REGISTRAR'S SIGNATURE <u>Arthur S. Frazee</u>

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

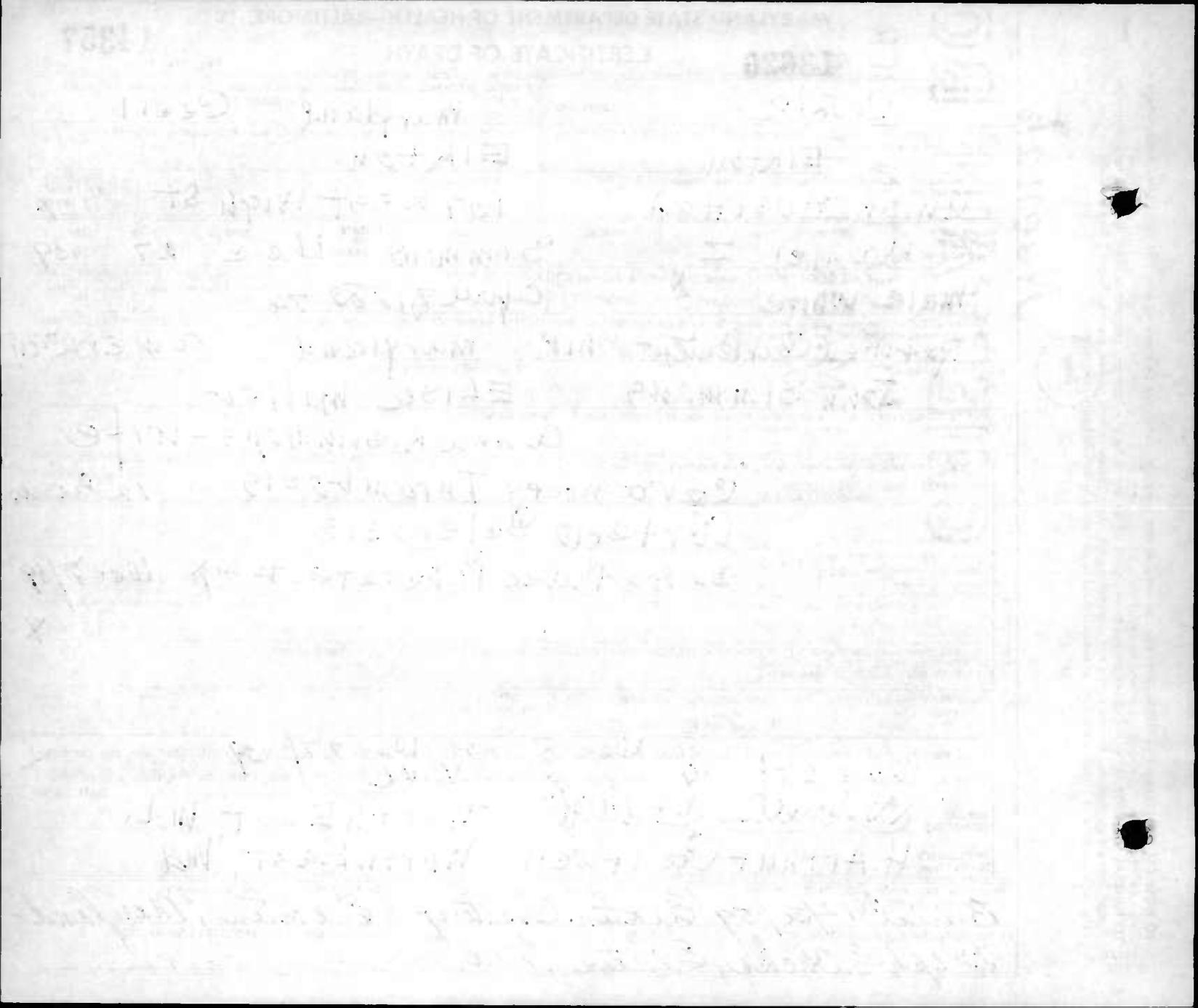
MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

14357

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <i>Cecil</i>	2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE <i>Maryland</i>					
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Elkton</i>	c. LENGTH OF STAY IN 1b c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Elkton 21</i>					
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <i>Union Hospital</i>	e. STREET ADDRESS <i>157 West High St</i>					
3. NAME OF DECEASED (Type or print) <i>Walter Z</i>	4. DATE OF DEATH Month Day Year <i>Dec 27 1959</i>					
5. SEX <i>Male</i>	6. COLOR OR RACE <i>White</i>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>April 7, 1883</i>	9. AGE (In years last birthday) <i>76 yrs.</i>	10. IF UNDER 1 YEAR Months Dots Hours Min. <i>0000</i>	11. IF UNDER 24 HRS. Months Dots Hours Min. <i>0000</i>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Retired Carpenter - Ship</i>		10b. KIND OF BUSINESS OR INDUSTRY <i>Ship</i>		11. BIRTHPLACE (State or foreign country) <i>Maryland</i>		12. CITIZEN OF WHAT COUNTRY? <i>America</i>
13. FATHER'S NAME <i>John Simmons</i>		14. MOTHER'S MAIDEN NAME <i>Eliza Miller</i>		Address <i>Anna R. Simmons - wife</i>		
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <i>No</i>		16. SOCIAL SECURITY NO. <i>INFORMANT</i>				
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>420.1</i>		DUE TO <i>Coronary Thrombosis</i>		INTERVAL BETWEEN ONSET AND DEATH <i>12 hours</i>		
Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause last. (b) DUE TO (c)		Arterio Sclerosis				
DUE TO (c)		SupraPubic Prostatectomy		19. WAS ANU PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)						
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 1b.)				
20c. TIME OF INJURY Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <i>Dec 8, 1959</i> , to <i>Dec 27, 1959</i> , that I last saw the deceased alive on <i>Dec 27, 1959</i> , and that death occurred at <i>Elkton</i> , from the causes and on the date stated above.				ADDRESS (Street, city or town, state) <i>North East, Md.</i>		DATE SIGNED
ACTUAL SIGNATURE <i>H. Arthur Cantwell</i>		M.D.				
PHYSICIAN'S NAME (Type) <i>H. Arthur Cantwell</i>						
22a. BURIAL, CREMATION REMOVAL (Specify) <i>Burial</i>		22b. DATE THEREOF <i>12/30/59</i>		22c. NAME OF CEMETERY OR CREMATORIUM <i>Elkton Cemetery</i>		22d. LOCATION (City, town, or county) (State) <i>Elkton, Maryland</i>
23. FUNERAL DIRECTOR'S SIGNATURE <i>Dolph E. Hicks, Elkton, Md.</i>		ADDRESS		24a. REC'D BY REGISTRAR DATE <i>JAN 6 '60</i>		24b. REGISTRAR'S SIGNATURE <i>Arthur S. Tracy</i>



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

13618

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Cecil		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Md.		b. COUNTY Cecil		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rising Sun		c. LENGTH OF STAY IN 1b 5 yrs.		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) X Rising Sun		d. STREET ADDRESS 17 Buckley Ave.		
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 17 Buckley Ave.				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				
3. NAME OF DECEASED (Type or print) MINNIE		First E.	Middle E.	Last STOUGH	4. DATE OF DEATH December 20 1959	Month December	Day 20	Year 1959
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH November 12, 1874		9. AGE (In years last birthday) 85 yrs.	10. IF UNDER 1 YEAR Months 0	11. IF UNDER 24 HRS. Days 0	12. IF UNDER 24 HRS. Hours 0
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) York County, Pa.		12. CITIZEN OF WHAT COUNTRY? U.S.A.		
13. FATHER'S NAME Solomon Eisenhower		14. MOTHER'S MAIDEN NAME Sarah Wilhelm						
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. None		INFORMANT Mrs. Harold R. David		Address Rising Sun, Md. 17 Buckley Ave.		
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 453.3		DUE TO Pulmonary embolism		INTERVAL BETWEEN ONSET AND DEATH 2 hours				
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b)		DUE TO Acute thrombophlebitis		4 days				
		DUE TO Phenylbenzodiazepine		3 years				
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) Bedridden due to hip fracture						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) Bedridden due to hip fracture						
20c. TIME OF INJURY Month, Day, Year Hour a. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> at work <input checked="" type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) Rising Sun, Md.		(State) Pa.
21. I certify that I attended the deceased from 5 to 12/20 , 19 59 that I last saw the deceased alive on 12/20 , 19 59 , and that death occurred at Rising Sun, Md. from the causes and on the date stated above.						ADDRESS (Street, city or town, state) Rising Sun, Md.		DATE SIGNED 12/20/59
ACTUAL SIGNATURE Neil Taylor		M.D.						
PHYSICIAN'S NAME (Type) Neil Taylor Jr								
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF Dec. 23 1959		22c. NAME OF CEMETERY OR CREMATORIAL Shiloh Union Cemetery		22d. LOCATION (City, town, or county) York County, Pa.		(State)
23. FUNERAL DIRECTOR'S SIGNATURE J. Carl Tyson		ADDRESS Rising Sun, Md.		24a. REC'D BY REGISTRAR DATE DEC 22 '59		24b. REGISTRAR'S SIGNATURE Charles J. Hause		

TO HOSPITAL & ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, it should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

13621

CERTIFICATE OF DEATH

Reg. Dist. No.

13619

1. PLACE OF DEATH a. COUNTY Cecil		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE Md.		b. COUNTY Cecil		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Roxton		c. LENGTH OF STAY IN 1b 3 days		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) X Rising Sun		d. STREET ADDRESS		
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Union Hospital						e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
3. NAME OF DECEASED (Type or print)	First Clauss	Middle	Last Tassick	4. DATE OF DEATH	Month Dec.	Day 7	Year 59	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> UNKNOWN <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 1892	9. AGE (In years last birthday) 67 yrs.	10. IF UNDER 1 YEAR Months 0	11. IF UNDER 24 HRS. Days 0	12. IF UNDER 24 HRS. Hours 0	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Laborer		10b. KIND OF BUSINESS OR INDUSTRY Farm Work		11. BIRTHPLACE (State or foreign country) Germany		12. CITIZEN OF WHAT COUNTRY? Unknown		
13. FATHER'S NAME Unknown				14. MOTHER'S MAIDEN NAME Unknown				
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) Unknown		16. SOCIAL SECURITY NO.		17. INFORMANT O.B. Wilson		Address Colora, Md.		
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 446X DUE TO Bilateral Bronchopneumonia INTERVAL BETWEEN ONSET AND DEATH 3 days								
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.		(b) Uremia DUE TO Neurosclerosis 2 wks				?		
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) Generalized Arteriosclerosis 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>								
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)						
20c. TIME OF INJURY Hour a. m. p. m.	Month —	Day 19	Year —	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) —	20f. (City or town) —	(County) —	(State) —
21. I certify that I attended the deceased from 5 Dec. 1959 to 7 Dec. 1959, that I last saw the deceased alive on 7 Dec. 1959, and that death occurred at 7 Dec. 1959, M, from the causes and on the date stated above.								
ACTUAL SIGNATURE Klaus H. Huchner	M.D.		ADDRESS (Street, city or town, state) North East Rd		DATE SIGNED 7 Dec. 59			
PHYSICIAN'S NAME (Type) Klaus H. Huchner								
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF Dec 10. 1959	22c. NAME OF CEMETERY OR CREMATORIUM West Nottingham		22d. LOCATION (City, town, or county) Colora		(State) Md.		
23. FUNERAL DIRECTOR'S SIGNATURE J. Earl Tyson		ADDRESS Rising Sun, Md.		24a. REC'D BY REGISTRAR DATE DEC 10 '59	24b. REGISTRAR'S SIGNATURE John E. Turner			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 1 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

Item 1 Film G254 1-4-60 et

13622

CERTIFICATE OF DEATH

Reg. Dist. No.

13620

1. PLACE OF DEATH a. COUNTY Cecil		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Elkton		c. LENGTH OF STAY IN 1b 21	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Private home		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Elkton	
3. NAME OF DECEASED (Type or print) First Clara		4. DATE OF DEATH Middle Thompson Last December	
5. SEX Female		6. COLOR OR RACE Negro	
7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH July 25, 1881	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY 11. BIRTHPLACE (State or foreign country) Maryland	
13. FATHER'S NAME John Thomas		14. MOTHER'S MAIDEN NAME Martha Brown	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO. 218-38-3744	
17. INFORMANT Martha Dorsey-226 High St., Elkton, Md.		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]		INTERVAL BETWEEN ONSET AND DEATH	
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 593X		3 weeks	
DUE TO Uremia			
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b)		10 Years	
DUE TO Chronic Parencephalitis, Nephritis			
(c) Aortic Insufficiency		10 Years	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from June 9, 1959, to December 17, 1959, that I last saw the deceased alive on December 17, 1959, and that death occurred at 2 A.M., from the causes and on the date stated above.			
ACTUAL SIGNATURE <i>James L. Johnson</i>		ADDRESS (Street, city or town, state) 215 East High Street Elkton, Maryland	
PHYSICIAN'S NAME (Type) James L. Johnson M. D.		DATE SIGNED 12/18/59	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 12/28/59	
22c. NAME OF CEMETERY OR CREMATORIAL Providence Cem.		22d. LOCATION (City, town, or county) Elkton, Maryland	
23. FUNERAL DIRECTOR'S SIGNATURE <i>Elvin R. Bell</i>		ADDRESS 909 Poplar St.	
		24a. REC'D BY REGISTRAR DATE DEC 22 '59	
		24b. REGISTRAR'S SIGNATURE <i>Arthur S. Kline</i>	

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MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

13621

CERTIFICATE OF DEATH

Reg. Dist. No. 96

1. PLACE OF DEATH a. COUNTY Cecil		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE District of Columbia	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Perry Point		c. LENGTH OF STAY IN 1b 1 days	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Veterans Administration Hospital		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Washington 47X-3	
3. NAME OF DECEASED (Type or print) First QUINCY		4. DATE OF DEATH December 10, 1959 Month Day Year	
5. SEX Male		6. COLOR OR RACE Yellow	
7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/>		8. DATE OF BIRTH 2-26-91	
9. AGE (In years last birthday) 68 yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Head Waiter		10b. KIND OF BUSINESS OR INDUSTRY Restaurant	
11. BIRTHPLACE (State or foreign country) California		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Frank Que Duck		14. MOTHER'S MAIDEN NAME Jont Shee Quon	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) Yes		16. SOCIAL SECURITY NO. WW-I 123-10-0537 Hospital Records, VA Hospital, Perry Point, Md.	
17. INFORMANT		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 463X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause last. (b) DUE TO (c) Thrombophlebitis left femoral vein Gangrene of the left lower extremity		INTERVAL BETWEEN ONSET AND DEATH 3-4 days	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (c)		unknown	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Hour o. m. 19 p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from December 9, 1959, to December 10, 1959, at VA Hospital, Perry Point, Md. and observed the deceased in a state of unconsciousness and death occurred at 6:26 A.M. ADDRESS (Street, city or town, state)		DATE SIGNED	
ACTUAL SIGNATURE <i>J. L. Garey</i>		M.D. V.A. Hospital, Perry Point, Md. 12-11-59	
PHYSICIAN'S NAME (Type) J. L. GAREY		Clinical Pathologist	
22a. BURIAL, CREMATION, REMOVAL (Specify) Removal		22b. DATE THEREOF 12/10/59	
22c. NAME OF CEMETERY OR CREMATORIAL Arlington National		22d. LOCATION (City, town, or county) Ft. Myer, Virginia. (State)	
23. FUNERAL DIRECTOR'S SIGNATURE PENNINGTON & SON		ADDRESS Havre DeGrace, Md.	
		24a. REC'D BY REGISTRAR DATE DEC 17 '59	
		24b. REGISTRAR'S SIGNATURE <i>John S. Penn</i>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4
 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

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MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

Items 8 & 9, Film G-254 1/12/60.cac.

13622

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Cecil		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MARYLAND	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Perry Point, Maryland		c. LENGTH OF STAY IN 1b 11 days	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION VA Hospital		e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Elk Mills	
3. NAME OF DECEASED (Type or print) Edward W. WHITLOCK		4. DATE OF DEATH December 10 1959	Month Day Year
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 14-1-87 1-24-88
9. AGE (In years last birthday) 7271 yrs.	10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Janitor	11. KIND OF BUSINESS OR INDUSTRY Unknown	12. BIRTHPLACE (State or foreign country) Earlville, Maryland
13. FATHER'S NAME JAMES WHITLOCK	14. MOTHER'S MAIDEN NAME Susie Chambers.	15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) Yes	
16. SOCIAL SECURITY NO. 218-10-8867	INFORMANT Hospital records, VAH, Perry Point, Md.	Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Broncho-pneumonia Bilateral, Unresolved			
204.2 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Monocytic Leukemia			
Unknown			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (c) Arteriosclerosis - Generalized.			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. VA		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that death occurred at 12:12 AM from the causes and on the date stated above. ADDRESS (Street, city or town, state) J. L. Garey M.D. VAH, Perry Point, Maryland			
ACTUAL SIGNATURE PHYSICIAN'S NAME (Type) J. L. GAREY, MD Clinical Pathologist			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF Dec. 12, 1959	
22c. NAME OF CEMETERY OR CREMATORIAL Bethel		22d. LOCATION (City, town, or county) (State) Chesapeake City, Md.	
23. FUNERAL DIRECTOR'S SIGNATURE PIPPIN FUNERAL HOME, Elkton, Md.		24a. REC'D BY REGISTRAR DEC 15 '59	24b. REGISTRAR'S SIGNATURE Arthur S. Kraus

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending Physician and completely filled in, it should be filed with page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

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MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No. **13623**

13663

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

1. PLACE OF DEATH a. COUNTY Cecil		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Md.		b. COUNTY Cecil			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cecilton		c. LENGTH OF STAY IN 1b all life		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) X Cecilton		d. STREET ADDRESS			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
3. NAME OF DECEASED (Type or print)		First Alexander	Middle Wilson	Last	4. DATE OF DEATH 12 9 1959	Month 12	Day 9	Year 1959	
5. SEX M	6. COLOR OR RACE C	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	8. DATE OF BIRTH Feb. 1876	9. AGE (In years last birthday) 83 yrs.	IF UNDER 1 YEAR Months 83	IF UNDER 24 HRS. Days 0	Hours 0	Min. 0	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Laborer		10b. KIND OF BUSINESS OR INDUSTRY Ordinary work		11. BIRTHPLACE (State or foreign country) Cecil Co. Md.		12. CITIZEN OF WHAT COUNTRY?			
13. FATHER'S NAME Charles Wilson				14. MOTHER'S MAIDEN NAME Elizabeth Brown					
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no		16. SOCIAL SECURITY NO. Unknown		17. INFORMANT Annie Wise Cecilton, Md.		Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]									
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Acute Coronary Occlusion INTERVAL BETWEEN ONSET AND DEATH									
420.1 DUE TO									
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Arterio Sclerosis Extreme									
DUE TO									
(c)									
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)									
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>									
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)							
20c. TIME OF INJURY Hour a. m. p. m.		Month, Day, Year 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) Cecilton	(County) 	(State)
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and find that death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .									
ACTUAL SIGNATURE <i>R. C. Dodson</i>		DATE SIGNED M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input type="checkbox"/>							
EXAMINER'S NAME (Type) R. C. Dodson M.D.		12-9-59							
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 12/12/59		22c. NAME OF CEMETERY OR CREMATORIAL Cecilton Cem.		22d. LOCATION (City, town, or county) Cecilton Md. (State)			
23. FUNERAL DIRECTOR'S SIGNATURE <i>John P. Bell</i>		ADDRESS 909 Poplar St.		24a. REC'D BY REGISTRAR DEC 14 '59		24b. REGISTRAR'S SIGNATURE Arthur S. Kraus			

WISCONSIN STATE DEPARTMENT OF HEALTH - SANITATION
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

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